MICHAEL CAROLAN

Breaking Point: The Search for a Postwar Grandfather

Two men were driving in an ambulance to a small town in south-central Missouri known as the "Gateway to the Ozarks"—the ancient range of mountains, rivers, and caverns stretching from Oklahoma to Illinois. It was one o'clock Sunday morning, the end of a four-day Fourth of July weekend in middle America in the late nineteen fifties. The fire departments, marching bands and war heroes that had paraded down the Main Streets of places like Lebanon and Mountain Grove were fast asleep.

The two men, Lawrence Welch and his twenty-one-year-old son-in-law, Don Seelke, had dropped a patient off at the county hospital in a medium-sized city called Rolla and were returning to Salem when they came upon something of a rarity in that part of the country and at that hour—the scene of a single automobile accident. A two-tone green and white Ford coupe lay upside down in a gently sloping field, its headlamps illuminating the ground in two small circles.

A flatbed truck idled on the shoulder of the road, its brake lights red, the yellow hazard lights flashing. A farmer named Ray Johnson and his wife were out in the field looking for the driver of the overturned automobile and any passengers who may have still been breathing but unable to call for help. "The car's empty and we can't find no one out here," the man called out. "Got any light?"

The two men joined the couple with a flashlight from the ambulance's glove compartment. After a few minutes of swishing through the tall grass, Mr. Seelke's foot hit something hard. It was there, in a dry shallow ditch twenty feet behind the Ford, that he found the body of the driver: a forty-four-year-old dentist, veteran of the Second World War, and my grandfather.

Charles Woodrow Felt was considered handsome in a movie star kind of way: a Gary Cooper or a Gregory Peck. Tall and square-jawed, with dark eyes and black wavy hair, he was by all accounts at once friendly and shoot-from-the-hip. When Mr. Seelke came upon his body in a field six miles south of Rolla, my grandfather's skull was fractured, his rib cage was crushed, his internal organs hemorrhaged, and his left arm and shoulder were twisted unnaturally underneath him. His wristwatch ceased to run at a quarter past one.

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The patrolmen called to the scene that night measured the distance my grandfather's automobile traveled after it left the pavement: four hundred and seventy-four feet. Mr. Johnson, the truck driver, told the officers that my grandfather's 1956 Ford Crestliner sped past them as they headed south on Highway 72, traveling so fast that the couple expected to find the automobile smashed up "in pieces" farther down the road, which they did.

Funeral homes in small towns in those days ran the ambulance services, so Mr. Welch and Mr. Seelke loaded my grandfather's body into the back of the oversized station wagon and took him to the Warfel Funeral Home in the center of the town he had called home for eighteen years.

Calls were made: my grandmother was visiting her mother in the north part of the state with her son. My mother, seventeen at the time, was at home. She had decided not to accompany him to the stock car races in Rolla from which he was returning when he died. When the Dent County sheriff came to the door at three in the morning, she was sleepy-eyed and in her slippers. The neighbor across the street heard my mother shrieking the remainder of the night until the newspaper was delivered several hours later.

On the front page was my grandfather's picture. The article said he tried "to pull back on the roadway" while rounding a "well known curve." It did not mention the accident report, which said nothing about the driver attempting to pull the car back onto the roadway. The box on the report, "going straight through," was checked rather than the box "turning."

In fact, the single most important factor about the accident went unmentioned in the newspaper and the police report. Officers found a bottle of powerful central nervous system depressants inside the automobile—an addictive barbiturate called phenobarbital—that held the key to my grandfather's slow, degenerative illness, a disorder that no one at the time seemed able to name.

As a long shot, I contacted the patrolman who signed the report the morning of July 7, 1957. Sergeant Thomas Pasley was ninety-two years old and did not remember the case. I asked him what he would have done had he found a bottle of pills at an accident scene. Would he have noted it in his report?

"Why, son?" he asked me back, waiting for me to answer. "If they were pills from the doctor, why on earth would I write that down?"

Instead, Mr. Pasley checked the box on the report that said "Had not been drinking."

Known by various nicknames—Bud, Charlie, Woodrow, Doc, Blackie—my grandfather, was among other things, a popular small-town dentist and a veteran of the Second World War. Overseas for nearly three years, Captain

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Felt took care of the teeth, jaws and faces of thousands of soldiers who fought across Europe: at Normandy, at the Battle of the Bulge, at the crossing of the Rhine. His job was to fill cavities, pull teeth, and insert new ones. But he also wired back together the first to enter French villages overrun by Germans—the infantrymen whose jaws were shredded by shrapnel, the sharpshooters whose eyes had been blown out, the tank gunners whose cheeks resembled nothing more than moldy cheese. My grandfather witnessed what most human beings will agree is the stuff of nightmares and horror films.

Before he left for Europe, Charles Felt was outgoing, prankish, lighthearted. Afterward, the change was immediate and apparent. His wife and his closest friends found him withdrawn. He had difficulty falling asleep, difficulty staying awake. He preferred to be alone in his office above the Salem Bank downtown, sometimes all night long. He was at times strangely hyperactive behind the dental chair and the wheel of his automobile.

His marriage became strained. He began ordering industrial-sized bottles of pills he would never dispense to his many patients. His moods fluctuated wildly between euphoria and depression in the daytime and rage in the middle of the night. And most notably, he developed an increasing need for the adrenaline rushes to which he became accustomed in the European war hospitals flooded with casualties. Only driving his automobile very fast seemed to soothe him as he adjusted to small-town life after the war. That and the medicine commonly prescribed by psychiatrists of the day for symptoms similar to his.

The pills found scattered in my grandfather's automobile the night he drove off the road were similar in structure to medicine used on soldiers for what was then called "combat exhaustion." In the early 1940s, psychiatrists treating soldiers in the North Africa and Sicily campaigns stumbled upon an exciting property of a particular barbiturate called sodium pentothal. They found that it put the mentally suffering combatant into deep trance, sometimes for days on end when enough was administered, and that the soldier could often remain semiconscious and even answer the doctor's questions.

The doctors believed they were bringing to light the buried memories of the particular trauma thought to be the cause of the soldier's seeming apathy and inability to fight. Later, doctors discovered that the drug and their methods worked just as well on the other half of psychiatric casualties—the support personnel, like my grandfather, who didn't see combat but treated the wounded, handled the dead, or were near enough to the front lines to perceive a threat to their life. They were men who experienced symptoms similar to those once thought to be reserved for the man who had seen combat. But they were "cured" by the treatment as well and ready to be returned to duty or to fight, whichever might have been the case.

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So for the decade between my grandfather's return from the fields of Europe in 1946 and his death on a gentle slope in Missouri, he was, in effect, treating himself with the best medicine doctors at that time had to offer.

Over the years, I have wondered about my grandfather's premature death: how it came to happen and the role his experiences in hospitals across Europe may have played in his illness—a disorder only shamefully acknowledged and then swiftly swept under the rug. Would he have fared better were he alive today, with the new awareness of the difficulties that all veterans—whether in combat or behind the lines—bring back with them from the battlefield? What it came down to in the end was that I wanted to discover and come to know the grandfather I never knew.

THE MISSING GRANDFATHER

Salem, population 5,000, sits on the northern edge of a geological plateau and range of grasslands and mountains, sinkholes and mossy forests. The Ozarks stretch across parts of five states in the middle of the country: Oklahoma, Kansas, Missouri, Arkansas, and Illinois.

Its central location, trout-fishing and scenic National Park along the Current River make Salem popular in the region. You can get a bite of lunch for less than three and a half dollars and rent a canoe for the day for less than ten.

My grandfather was a fixture there—the smiling, easygoing small-town dentist whom you could stop along the street and tell about your toothache, the upstanding member of the Methodist church, the Masons, the Salem Country Club. So much so that when I visited the town a couple of years ago, several people I ran into on the street had heard of his death more than fifty years ago. It's a community that didn't let him down, even in death.

My grandfather died nine years before I was born. My grandmother rarely spoke about him. My mother immortalized him through the same pleasant stories: he took her out of school to go fishing, built a float for the neighborhood kids for the Independence Day parade, provided free dental work for the indigent hillbillies outside of town.

One story concerned how he and his brother-in-law were drinking in the basement one day and watching the new washing machine at work. When their wives came home, the two sat at the bottom of the stairwell, the water rushing out of the top of the washing machine onto the floor, suds all about them.

"The tide is in!" they called up. The double entendre of the newly marketed "Tide" detergent soap was the punch line at which everyone always laughed.

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Only twice was I told anything about his war experience, and only after I asked. One day, my grandmother told me, when he was walking near a hospital in France, a mortar landed nearly on top of him. His reaction was the one thing that struck me: he'd been blown down and when he sat up, he put his hands to his face and was horrified. He felt blood streaming down his face. He'd been hit in the head with shrapnel.

Moments later, he looked at his hands and focused on mud and water from the blast. But it's enough to traumatize, say the experts. The body and mind under attack, even if it isn't wounded but thinks it is, is enough to alter brain chemistry and its memory of the experience.

The other war story took place in a hospital after artillery shelling knocked out the electric lights in the hallway in which my grandfather was walking. Blackie dropped to the floor reflexively, in the darkness, and grabbed hold of the nearest object to pull himself back up. The lights returned. He found himself holding onto body parts from a hospital cart. Specifically, the upper torso—an arm, a neck, and even the head, the story went—of a badly mangled GI.

My mother tells the tale in such detail that it seems to me that it happened to her as well. An amputated arm on a hospital cart is plausible. But an entire torso? That sounds like a nightmare, either that my grandfather had and told to her, or that my mother herself may have had.

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PRETTY BABY

Charles Woodrow Felt grew up in a small farming community in north-central Missouri, thirty miles north of the Missouri River, called Mendon. The town was settled by New Englanders who came from Illinois following the Santa Fe Railroad as it laid track across the state. One of them was my grandfather's namesake, *his* grandfather, Charles Davis Felt, a great-grandson of George Felt, who came to Salem, Massachusetts, with Captain John Endicott in 1628. It was during the time in this country when every boy could grow up to be president and old Felt named his son, born in 1884, for President Chester Arthur. Chester Felt kept with tradition and named his son, my grandfather, after the President at the time of *his* birth, Woodrow Wilson—inaugurated in 1913.

My mother remembered Charles Davis, the man who so hoped for his children to live in the White House: he used to drive around Mendon with his pet hog in the front seat of his pickup truck.

My grandfather began life precociously: his mother, a diminutive Swiss-German woman named Bernah, recorded that he won first prize for being the "prettiest baby" in the baby show at the Mendon Street Fair. The photograph

was passed down to me, and at eight months old, he is, in fact, a pretty baby.

He was by most accounts sensitive and overprotected by his mother: after he was injured in an automobile accident in 1934, she had him flown by airplane — unusual by the standards of the day — to a hospital "to avoid the jarring of a drive by motor car." He married my grandmother in 1938 and moved a couple of hours downstate to Salem, where his parents lived and where he opened a dental practice. Five years later, America had entered the war and planned for a corps of twenty-two thousand dentists to care for the teeth of millions of servicemen.

On May 28, 1943, the Army gave my grandfather a physical at its induction center in St. Louis: six feet one inch, one hundred and fifty pounds, with a sitting pulse of seventy-eight beats per minute. He had a "depressed fracture" in the left front region of his head from a "skull accident." He was missing six teeth and had no history of "nervous and/or mental" disease.

THE DISORDER OF THE 20TH CENTURY: WAR

In May 1944 — a month before the Normandy landing on the coast of France — my grandfather was among the six hundred doctors, nurses, and staff who built the 186th General Hospital about an hour east of London. The thousand-bed hospital occupied a sprawling meadowland that was once a medieval deer park with elm, oak and ash trees: one hundred and fifty-eight huts with corrugated metal roofs and concrete floors, ten portable tents for an additional five hundred patients, five surgical rooms, eight fully staffed patient wards, a three-hundred-and-sixty-four-seat movie theater, a post office, and a barber shop.

The hospital was to be ready in just one month to receive the hundreds of casualties expected after the Americans invaded France. When D-Day arrived, the medical team at the hospital had lost a quarter of its members to other units. Under normal conditions my grandfather worked in a five-room ward with three dentists, an oral surgeon, and fifteen technicians, hygienists, and clerks. But when casualties mounted on litters on the grassy field in front of the hospital — two hundred and twenty-four soldiers on June 11 alone — he and others pitched in around the clock, much of the time finding themselves in situations with which they had little or no experience.

Officers and enlisted with even a modicum of surgical experience were pulled in to help perform operations to save lives. Ear, eyes, nose, and throat specialists were in short supply or attending others. Dentists studied the anatomy of the head, so my grandfather was a good candidate for sewing up the hole in a cheek or placing pins in a cracked palate.

He made castings of bone blown away by bullets, refit jaws with wires and

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posts, fit contraptions around soldiers' heads to keep his work aligned. He screwed plates and bridges into the gums of men, with their stumps of once perfect teeth, exposed red and black tissue, and oftentimes, torn tongues. American faces lay before him, waiting for stitches, for implants to fit where teeth had once been, for prosthetic eyeballs he fashioned from compounds used to make dentures.

Two weeks later, the 186th General had seen more than twelve hundred wounded come through its doors. It was the first time my grandfather had seen that number of human bodies troubled by anything other than tooth decay.

Dr. Jonathan Shay, a Department of Veterans Affairs psychiatrist and author of the book *Odysseus in America: Combat Trauma and the Trials of Homecoming,* said that facial injuries provoke an intense emotional reaction in all human beings. It is the face that uniquely identifies humans as different from one another: a foot is a foot, but a face is unforgettable.

"A trauma dentist—in a sense what your grandfather was forced to do likely without a shred of training—has a constant diet of facial disfigurements," Dr. Shay said. "Whole jaws shot away, sides of faces blown off, people with their eyes destroyed. It is horrific to think of what he likely had a steady diet of and could not get away from."

During the last six months of 1944, he worked on more than two thousand three hundred soldiers and a hundred civilians—an average of one patient every half hour. He wired seventeen jaws, sutured thirty-four mouth wounds, filled one thousand three hundred and forty-five cavities, pulled eight hundred and three teeth, and fit twenty-four eyes: dentists with their manual dexterity were found adept at painting and fitting prosthetic eyeballs.

It wasn't necessarily the number of patients that overwhelmed my grandfather, it was that the military didn't prepare him for what he was about to see. While my grandfather spent nine months preparing with the 186th General Hospital in the middle of Kansas, records show the soldiers did little else than basic drills, military etiquette, and hospital procedure.

For instance, for two weeks in August 1943, the twelve-man dental unit set itself up in tents out on the prairie where it practiced as a "field hospital." The "lack of training equipment" was "a handicap" and the dentists had to borrow a chair and a surgical supply box from another unit so they didn't bake in the summer sun all day with nothing to do.

"Then the military throws the civilian medical caregiver into a cauldron of dying and mutilated American service members," Dr. Shay said. "It just wrecks them psychologically. They are overwhelmed by their helplessness in the midst of the destruction."

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A few years ago, I tracked down a supply officer living in Michigan who served with my grandfather when he was in France and had a cavity filled by him. He said that there was another dentist in the clinic named Schott.

"When you came to your appointment," he said, laughing, "the secretary there asked you if you wanted to be 'shot' or 'felt.'"

A bunkmate of my grandfather's I contacted a few years ago told me that Charles Woodrow pulled pranks on the commanding officer of the 186th General, "who didn't take it so well."

"I think he pissed the CO off because, as a civilian dentist, he wasn't going to follow 'regular Army' rules," he said.

My grandfather evidently asked patients about their girls, their hometowns, the sports they liked, whether they fished or not. After the war, he wrote letters and sent coffee to a particular German POW whom he befriended. Clearly, he experienced a kind of relentless parade of the individual faces of America, and even the world. But many were faces he was unable to forget, lives from the battlefront for which, ultimately, he could do very little.

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FACING ANOTHER DAY

Three years after I was hospitalized with major depression, my grandmother came to visit me where I lived outside of Washington, D.C. She was seventy-five years old and flew from Sun City, Arizona. I think she felt enough time had passed from my battle with mental illness to share what it was like to live with another who had demons of his own—my grandfather in the throes of his trauma and addiction.

She brought a brown folder containing letters my grandfather had written to her during the war. "The strangest thing is to be one man before and a different man after," she said, referring to him prewar and postwar. "I knew something was wrong the moment I laid eyes on him at Union Station in St. Louis when he returned."

He was fine for the first several months, happy to be back with his family and friends. Then he stayed awake through the night or fell asleep in his office downstairs, in a chair, with a piece of hard candy tucked in his cheek. He began taking his car out in the middle of the night, racing it up and down the street—all common symptoms of what today is called trauma. But his symptoms continued, progressively worsened, and the culture at the time—picture perfect—turned its head for as long as it could. Toward the end, townspeople, his patients, his livelihood, "would see him staggering from his office down the street in the morning," my grandmother said. "People had forgotten about the war by then. He had not come out of it."

One problem was that my grandfather was among the millions of men left in Europe for years after the Japanese surrendered as the "Army of Occupation." He cared for both American servicemen and German POWs in a converted cavalary barn in Liège, Belgium. Many officers were taking their own lives because they couldn't come home. He sent President Harry Truman a letter. His mother sent one, too. The national association of dentists published an editorial bitterly critical of the Army's slow release of thousands of its members: the delay was affecting the dental health of millions of Americans.

Later that night of my grandmother's visit, I read a letter that had been written to her from Cherbourg, France, in March 1946: "Sometimes Sweetie, really, I don't see how it can go on much longer. I wake up in the morning another 'nightmare' of a day ahead. I want to just go back to sleep to forget everything and dream I was home. I can't. I wake up with a head of nightmares and take a small shot and decide to face another day. I'm so damn low. I've thought many a time I couldn't take any more, but somehow I've struggled through."

MADE IN AMERICA: WAR NEUROSES AND THE GREATEST GENERATION

In a landmark study of fifteen hundred veterans of the Second World War, psychiatrists Norman Brill and Gilbert Beebe found that the treatment of what was then called "psychoneuroses" made relatively little difference in whether the American soldier improved at all. "Apparently neither the fact of psychiatric treatment nor its variety is reliably related to follow-up condition," the authors wrote in 1955. In fact, when psychiatrists asked the veterans their opinions of the change in their condition since leaving the service, three fourths answered that their health was worse.

The Army's intensive psychological profiling—a strategy still used today—didn't help either. During the war, nearly two million men were discharged for "neuropsychiatric reasons." Even after the war, well over half of all psychiatric cases developing two and three years out had passed the Army's classification system as "devoid" of any "psychiatric defects."

A pamphlet entitled "What's the Score in a Case Like Mine?" was provided to thousands of American men discharged from the Armed Services for psychiatric reasons. They were advised *against* "taking it easy for a while" or "loafing for a month," but to get back to work immediately. "Don't get mad" because the family "can't understand." If you don't want to play "competitive games," you should "saw wood, chop kindling, pound on a punching bag."

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"Remember that a man's condition is his own problem, whether it is a pain in the belly or an ache in his soul," the booklet concludes. "Try to whip it yourself. If you can't, don't hesitate to get help."

In 1945, the year the war ended, the Veterans Administration dedicated twenty-nine of its hospitals across the country—nearly one third—to one type of patient: the "psychoneurotic." The following year, well over half of all veterans in VA hospitals suffered with mental health problems and more than a half million were receiving benefits.

Psychiatrists of the day predicted calamity: more than one hundred and fourteen thousand beds for such veterans would be required by the year 1975. Never before had the psychologically traumatized veteran "largely influenced all plans for hospital expansion and new construction," one prominent physician wrote. And psychiatry profited as well: in the decade after 1940, the number of practicing psychiatrists in the country more than doubled, from nearly two and a half thousand to more than five and a half thousand.

At each VA hospital, a "reconstruction officer" coordinated bibliotherapy (reading), occupational therapy, as well as physical exercises and recreational activities. Famed Hollywood director John Huston was called upon to make a short documentary for the Army, which was subsequently suppressed, as the film reportedly didn't fit the Army's warrior image. "Let There Be Light" heralded the successful, Christ-like ministrations of the psychiatrist, who took babbling men at the beginning of the film and transformed them into cogent, friendly "Joes" by the end.

Concern went all the way to the White House. Nineteen days before President Roosevelt died in April 1945, he wrote to his secretary of war appreciating "the magnitude of the task of caring for the soldier who is emotionally sick as a result of combat." Roosevelt turned abruptly to speak about the "other" kind of soldier: ". . . the man whose service maladjustment is but a reflection of a long existent inadequacy."

The surprise to Roosevelt and others was that the men the military had so meticulously deemed psychologically fit on tests given at induction showed up after the war chronically drunk, jobless, and oftentimes divorced.

At one state mental hospital unaffiliated with the VA, a whole third of its patients were veterans—men who scored high on the Army's initial psychological exam, served overseas, and received "non-psychiatric" discharges. Now they were psychotic and locked up by the state.

At the same time, the "existent inadequacy" of which Roosevelt spoke was widespread: in a South Pacific psychiatric ward, three-quarters of the men showed a history of "neurotic adjustment" before entering the service.

"War neuroses are 'made *in* America,'" announced two noted psychiatrists.

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"They only come to light or are labeled in combat."

By the mid nineteen fifties, one hundred and seventy-two VA hospitals with more than one hundred and seventeen thousand beds for the psychiatric patient had been built in cities across the country. But the institutionalization movement didn't go over well with the prevailing stoic American war hero.

Stiff upper lips kept most veterans re-enacting their psychic wounds behind the closed doors of their homes, at their places of employment, or in their communities, not anywhere near the "looming presence of those massive, three-to-five-thousand-bed psychiatric hospitals," according to Jonathan Shay, the VA psychiatrist.

"The thought was that if I tell anybody what is going on in my nightmares or what goes through my mind as I come to a corner looking for snipers or a German 88 tank, they would throw me into that hospital and drop the key in Lake Huron," he said.

Not only could the veterans see the multistoried brick hospitals going up across the country, many knew someone who went into one of them and then never came out. "I am convinced that vast numbers of the vets just kept their mouths shut or just told the sunny stories."

The more distant the war became meant veterans' diagnoses changed from "combat neurosis" to the longer-term and more severe ones like "schizophrenia." American public opinion and psychiatry began enacting the cyclical forgetting.

"It's a way of saying it's his own fucking fault," Dr. Shay said. "This isn't the result of something that merely happened to this individual or that we as a nation caused to happen to him by putting him into this horrific situation. The later version became 'he was damaged goods to begin with.' You can probably guess at how enraged a man might become—who held his closest friend while he bled to death through his neck arteries and mouth—and this moron is talking to him about his mother."

Friends and patients in Salem, Missouri, were torn between blaming my grandfather or feeling sorry for my grandmother. At a bridge game one night, Blackie came in bloodshot and stumbling. A friend of the family leaned over to my grandmother, and said, "Trudy, I just don't know how you can stand it. You must be a wreck. He's just got to snap out of this. How long can this go on?"

As in all families with an active addict or trauma victim, my grandmother played a role not to be dismissed: she nagged him to "snap out of it" as well, and was so irritable and concerned with what the neighbors thought that he fled to the basement, where he crafted wooden lamps and bowls on a lathe, and indulged in his addictions.

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My grandfather likely experienced symptoms similar to schizophrenia toward the end of his life: the mania, the loss of touch with reality, hallucinations even. At his funeral, a prominent physician and friend spoke to my grandmother. She told me what he said. "That your grandfather . . . had he not died . . ." She shook slightly with nervousness, and made certain that we were talking about *my* grandfather and not *her* first husband. "Well, that he would have to be locked in an institution for the rest of his life."

The doctor's words wouldn't surprise Judith Lewis Herman, M.D., author of the book *Trauma and Recovery*. She believes that society—because it can't bear the responsibility of sending men into a battle that psychically ruins them—denies its culpability and blames the victim recurrently and across the generations. The military and the establishment must escape accountability for its crimes, Dr. Herman writes, and "does everything in [its] power to promote forgetting. If secrecy fails, the perpetrator attacks the credibility of his victim."

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THE CAREGIVER: WHAT HE DIDN'T DO WELL ENOUGH OR FAST ENOUGH

A few weeks before his death, my grandfather went to see a psychiatrist several times over a ten-day stay with his brother Arthur's family outside of Detroit, Michigan. My grandmother had left my grandfather at least twice by then, but after a short while came back to him. She threatened to leave him again if he didn't go to the doctor to find out what was wrong with his mind.

My grandfather's brother's wife, Irene, held late-night talks with him.

"He said that he had to make decisions in several cases, decisions that would end someone's life," my great-aunt said, referring to triage, the decision not to treat mortally wounded patients. "It bothered him more then than I had seen him bothered. Though he spoke about it as if it's just what you had to do."

My grandfather's experience is common among people who suffer a particular form of stress known as caregiver trauma.

"The people who have seen combat have a difficult time with what they did," said Richard Weidman of the Vietnam Veterans of America, a national association of veterans of that war. "The medics and caregivers have a hard time with what they didn't do well enough or enough of, or fast enough."

Caregivers and "noncombatants"—the millions of support personnel who in every war never pick up a gun and kill—are vulnerable to trauma as well. As psychiatrists studying the condition in 1951 put it: caregivers are without the possibility of "effective motor discharge of the emotions thereby engendered."

The difference between soldiers and how they deal with their disorders and caregivers is clear in support groups that meet today at Veterans Administration centers across the country, Mr. Weidman said. It is common to find caregiver veterans meeting separately from combat veterans.

One thing both groups have in common is substance abuse, alcoholism, and accidents. Doctors have long been making the connection between trauma and drug addiction in veterans. In one study, more than 90 percent of all hospitalized veterans with a trauma diagnosis had met the lifetime criteria for substance use disorders. In another study, researchers found that even thirty years after the Vietnam War, veterans with trauma were still more likely to die from accidents, drug addiction or suicide than any other cause.

"Everyone who suffers has their own set of videotapes running through their heads," Weidman said. He served in Vietnam as a medic himself. "It is not the generalities—it's the specifics. The faces, the specific people, their features, the procedure undertaken, their last breath . . . the nightmares are about . . ." He paused and I changed the subject.

My grandfather's nightmares disturbed my grandmother.

"They horrified her," Aunt Irene said, referring to my grandmother. "At several points, your grandfather raged all night long, cursing the Army, cursing the lives of both his mother and father, cursing everything. Now what would cause a man to do that?"

Trauma, addiction, and a man coming unraveled.

He was nervous and exhausted during his visit to his brother's family. He spent several hours getting ready in the bathroom before his appointment with the psychiatrist. The grooming may have paid off: the psychiatrist "promoted forgetting." He told my grandfather that absolutely nothing was wrong with him.

"It was like you could see the relief on his face," my grandmother said. "He was so happy that there was absolutely nothing wrong with him."

Less than two weeks later, he would be dead.

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REIZSCHUTZ

I began thinking about how the current generations of veterans might be faring after returning to a society and medical field that had changed in its view of trauma. I wondered about Sigmund Freud's theory on *Reizschutz*, developed after his experience with veterans of the First World War.

Freud believed that each person had a barrier that blocks excessive stimulation from flooding the central nervous system. When the barrier is suddenly and violently breached with a trauma, the nervous system is overwhelmed with stimuli it is unable to bind neurologically or psychologically into the

person. The barrier, the central nervous system, the person, all needed support, rest, and psychiatric help to build up the *Reizschutz* again, much like the treatment of the soldier then and today: "three hots and a cot" or plenty of food and rest.

How much of each varies with the individual, the situation, the trauma (amount over time), and the psychology of the individual. Freud introduced the concept of one size doesn't fit all.

Current treatment for the disorder consists of multiple layers: the soldier, the family, and the community are first educated. In psychotherapy, similar to the narcosynthesis of the Second World War, the soldier may re-experience the event in a safe, controlled environment, and then attempt to resolve the attendant anger, shame, or guilt. The soldier learns coping mechanisms for the memories and reminders, if and when they return, so that he or she doesn't become overwhelmed or emotionally numb. Psychiatric drugs like antidepressants and sedatives are used, though no longer of the barbiturate class.

What's now clear is that the trauma—whether on the battlefield, in an operating room, or at the hands of a physically abusive parent—doesn't ever leave the survivor but becomes manageable with the mastery of new coping skills.

I thought Richard Weidman of Vietnam Veterans of America might be able to answer the question about advances in treating post-traumatic stress disorder (PTSD). From his office in Washington, D.C., he said that as a Vietnam medic, he suffered from the disorder. At several points in mid-sentence during our conversation, he stopped speaking to me altogether. I thought maybe he had hung up on me, and then he came back on the line and said, "I just lost my train of thought, hold on."

I reminded him of the last thing he had said several times and he went on, each time, as if he had never stopped speaking. I wanted to ask whether this was an effect of the disorder, but I decided against it.

"I think the VA is providing the best care for the disorder," Mr. Weidman said. "But it's whether they will treat all the veterans that are going to need it. As a rule, and with the exception of the G.I. Bill, we've always treated our vets horribly. It's always an initial burst of funding immediately after the war and then suck wind."

Mr. Weidman said that the Bush administration attempted to rewrite science and raise the bar over which veterans had to jump to obtain benefits for mental health issues. "They wanted to redefine the term *mental disability*," he said. "They did everything they could to reduce care for the future of the men and women serving today."

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GATEWAY TO THE OZARKS

In 2002, I took my younger brother, my nephew and my own son to my mother's birthplace and to the nearby Montauk River, the waterway upon which my grandfather took my mother fishing. I wanted to see where my mother grew up, primped for her prom, where my grandmother made her happy nineteen-fifties home. I needed to see my grandfather's paneled office in his home, where he sat and sucked on his hard candy into the night.

I had been there before: my mother drove us through when I was a little boy, but I didn't recall any of it. I thought I would spend some time on the river he so loved and find out if anyone remembered him. My mother told me to start with my grandmother's best friend, Dorothy Dent.

I met her at the Blackberry Patch restaurant off of Main Street in Salem, where I bought her a turkey sandwich. Mrs. Dent was a prim, short woman in her late seventies. She wore large pearl earrings and a blue blazer.

She recalled that my grandparents could cut the rug at the golf club dances. But for forty years, my grandmother couldn't talk about her husband's death. In the 1990s, she finally brought the subject up with her best friend. When the time came, it wasn't trauma or PTSD that interested her. She read an article in *Ladies Home Journal* about today's addiction treatment programs.

"Your grandmother told me that it would be a lot different today," Mrs. Dent said. "She said that if he had been alive today, Doc Felt, that they have treatments and he might have had a chance."

I asked Mrs. Dent who else I might visit and she sent me to the wife of the town pharmacist at the time, Dolly Kuncel, who was ninety-three years old. She was said to be a gossip, so I was on my guard. She opened her door and let out a kind of squeal of delight that I had arrived. Dressed in her Sunday best, she wore a polka-dotted blouse, a necklace with pearls the size of large grapes. Her hair was glazed bluish white. When I asked my first question, her little eyes behind the large thick glasses lit up.

She said that my grandfather would send "his girl"—secretary—down to the pharmacy where Mr. McMurtry would fill the order. The secretary often had a prescription written out by my grandfather for a "fake patient." I asked her what the prescription was for.

Her eyes widened instantly: "Cocaine."

"Really?" I asked. "Not phenobarbital?"

"No." She said she was sure of it. "Cocaine."

I drove across town to visit one of the few older dentists in the area. He lived in a large brick rambler with a vaulted family room and large bay windows. Large photographs and watercolors of fish swimming and fishermen posing covered the walls. A stuffed deer head stared out from its wall mount.

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He wore a long-sleeve, collared shirt, western style, pockets with snap buttons. He was ruddy-faced, with a large nose, and leaned far back in an Early American pine rocking chair.

He spoke slowly, a southern Missouri drawl, and told me that my grandfather had welcomed him into town when he arrived fresh out of dental school. "Blackie was immortalized somewhat, you know," he told me. "A tragic and sudden death in a small town does that to a man."

I told him that I knew my grandfather had a problem with prescription pills and that he drank too much. He nodded and said that he had heard through a mutual friend that the police found a bottle full of phenobarbital pills in my grandfather's smashed-up automobile the night he died.

I told him about my own struggles with the unnamable, how it ran in the family, and, unexpectedly, he revealed how he had problems of his own, that he quit drinking more than ten years before.

"I thought, 'Here I am at age forty-five, and Blackie is gone,'" he told me. "Your grandfather never got to be forty-five. His addiction took him. And I thought to myself, 'Well, every year from now on is a bonus.'"

For a split second, I thought perhaps my grandfather had come back for a brief moment, and was there with the two of us—his old friend and drinking buddy and his grandson, both men formerly on self-destructive paths similar to his own.

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LIVING IS HELL

By the end of June 1944, after the rush of casualties from Normandy, my grandfather was, curiously, transferred from the 186th General to the 96th General a few miles up the road in central England. The 96th was one of a few specialized psychiatric hospitals in England that took in officers as well as enlisted men.

It is possible that my grandfather's first taste of war medicine—the mad rush of Normandy casualties—soured him and he went there to recuperate and was prescribed, or got hold of, barbiturates for the first time, though his military records make no mention of it. He appears on the rolls of the 96th General as a dentist, stayed one month, and transferred on to a nearby hospital where he stayed more than a year.

Barbiturates were standard issue in medicine: hospital anesthesiologists administered them before surgery to lower the dose of the required anesthetics, which in large doses could be fatal. A dentist might use a small amount before extracting a tooth to bolster the effects of sedatives. In the last six months of 1944, records show the hospital at which my grandfather worked doled out 37,630 tablets of phenobarbital of varying potency, second

only to its expenditure of alcohol. Even Adolf Hitler's doctor was said to be injecting cocktails of barbiturates, amphetamines, and cocaine to combat the man's mood swings and ailments.

Barbiturates' effects on the human body are more intense than alcohol's: the user's vision blurs, his speech slurs, sometimes unintelligibly. He might believe he can walk, only to find that his legs wobble like jelly. He may reach to pick up a glass, only to find it half a foot away from where he believed it was. Sluggish hangovers, more severe than those caused by alcohol, appear when the drug moves out of the bloodstream through the liver: sleeplessness, hallucinations, vomiting and convulsions are common. Too much of the drug impedes breathing, resulting in coma and death. Combined with alcohol, they can take the hyperactive edge off of an amphetamine high, allowing users to "equalize" their moods.

My grandmother told me that my grandfather, like many drug users, mixed uppers and downers together so that he could function throughout the day—not go too low or get too high. When she came to visit me in 1993, she told me that on the night of his death, he had been to the stock car races in Rolla, Missouri.

"See, he had seen all those cars racing around the track—I can just imagine that he's probably taken all these pills, uppers and downers, and he's higher than a kite, and he's got this car, and it's like he's at the races himself. So he went speeding around this curve and he just rolled over and was dead immediately."

The year of his death—1957—the U.S. Public Health Service for the first time called barbiturates "dangerous, intoxicating drugs, habit-forming and addictive when taken in large and uncontrolled amounts." Doctors of course viewed them as completely harmless, to be prescribed in unlimited quantities, and opposed defining a range of legitimate medical use. Even two years earlier, Senate subcommittees in the nation's capitol debated the issue.

"The experience of living with a barbiturate addict is a hell in which you wander helplessly, receiving little or no help from the medical profession," one Los Angeles woman pleaded. "Why don't you doctors think when you prescribe pills? Probably a pill is the easy way out for you—but how about the families who bear the later burden?"

The Senators were told that barbiturate production had increased four hundred percent in twenty years, and that every person in the country could have had, every year, twenty-four capsules of 0.1 grain potency. It was as severe as heroin. Doctors recommended keeping the addict under close supervision.

"Their beds should be provided with sideboards or else their bed should be a mattress on the floor so that if convulsions occur they will not fall to the floor," a doctor at the hearings testified. "Patients should not attempt to

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walk, bathe, or go to the bathroom unattended."

At the same time, prescription drugs were becoming a kind of sensation among the rebellious youth culture—the antithesis of the widespread complacency, economic boom, and suburban sprawl of America in the 1950s. Two months after my grandfather died on that curve, Jack Kerouac published *On the Road*, the drug-fueled (barbiturates and amphetamines) novel about young men driving across the country that precipitated the romanticizing of the drug culture in the following decade. The children of the Greatest Generation rebelled with the very substances with which their fathers secretly anesthetized.

And my grandfather indulged: the same drugs worked for him, for a time. They were the one thing that held him together, in which he found the seeming comfort and solace that no one could provide—the medical profession, the community, even his family. Kerouac was talking about my grandfather and the thousands of traumatized veterans of the Greatest Generation when he wrote about the "mad ones" who "burn, burn, burn, like fabulous yellow Roman candles exploding like spiders across the stars. . . ."

GETTING THE BOYS BACK TO THE LINES

Several years ago, I attended a reunion in Evansville, Indiana, of a half dozen veterans from the hospital with which my grandfather trained in the middle of Kansas. At the Evansville Holiday Inn, none of the men seemed especially traumatized.

Private Anthony Sepolio, a tall wiry man with wire spectacles from Katy, Texas, told me about the ten-piece orchestra he assembled at the hospital and the movie theater he helped build. On D-Day, he was painting a sign announcing a dance that Saturday night. "That went down the drain when I turned on the radio," he said. "The next ten days, well, it was like a living nightmare."

Mr. Sepolio helped carry the litters to the operating room, where they were stacked until the surgeons could get to them. "You're not talking just about D-Day, you know, because to us, that was just the beginning," he said. "We spent days and days and then months and months and then years and years getting those boys back to the lines. And when one went back, here come a hundred more."

I asked Mr. Sepolio whether he knew anyone with PTSD and he replied that he didn't. "You were to get through it, any way you could," he said. "To be perfectly honest with you . . . most of us drank our ways through."

Vincent Tricomi, a physician who came to the reunion from New York, was a technical sergeant in charge of the operating room. He had large hands

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and eyes that dropped to the floor when he spoke.

"It was hard on all of us," he said. "When you get so busy, you don't have time to step back and say, 'That is terrible.'"

He looked away, and in a soft voice for which I had to lean down to hear, he said, "It was a shock, I can tell you that."

When I was speaking to another veteran of the hospital a few moments later, Dr. Tricomi came up to me to make a correction. "I don't want to convey the fact that we were in trouble," he said, holding my forearm. "Listen, I mean the poor young fellows were getting killed and we were back from the front a little bit. So we were trying to do our part. That's all. You know, we basically felt the war through them."

I left the reunion feeling that my grandfather "felt" the war through the wounded and the maimed, and perhaps too much. I needed some relief, and thought I'd try to find whether any close friends of my grandfather's were still living. My mother told me that an old friend of her father's was in a nursing home in Missouri.

Doc McLeod, Salem's osteopath, was ninety-one-years-old and still alert. He told me a story about a camping trip on which my grandfather became the butt of a joke. Evidently, the owner of the campground invited my grandfather and his friends to have drinks at his home. "We told [the owner] that Blackie wasn't right in the head," Doc McLeod said, referring to my grandfather. "We said that he came from a good family but his wife sent him up here with us to get him better."

When it came time for cocktails, the owner served all the men in the party except my grandfather, refusing the rest of the evening to serve him an alcoholic drink.

It made sense to me somehow that my grandfather's unspeakable trauma, its attendant addiction, shame, and secrecy came to this in the late nineteen fifties. What else do people in a culture consumed by material prosperity and superficialities do with something as complex and unwieldy as memory, dismemberment, suffering, and mental health?

"He was the butt of the jokes on that whole trip," Doc McLeod said. "He got peeved when we came home and said he was never gonna go on a trip again. That he was going to sell all that tackle—his rods, his reels, the whole thing. He took it all back a while later."

I didn't ask about the war. Doc McLeod brought it up, saying that it "ruined him."

"He was ashamed, you know, of the whole thing," he told me. "And he got to be a loner and slowly, after a time, well . . . he pulled away from everyone." Away from his mother, his wife, his son and daughter, and finally himself—racing alone in a dark coupe across a field in south-central Missouri,

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